STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Manassas Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 Rixlew Lane Manassas, VA 20109	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to ensure all discharge needs were met prior to discharge from the facility for one of 43 residents in the survey sample, Resident #136.The findings include:For Resident #136 (R136), the facility staff failed to ensure needed durable medical equipment (DME), a bedside commode, was delivered to the residents home prior to discharging them from the facility to reside independently in a multi-level home with a bathroom located up 13 steps on the second level when they were unable to negotiate stairs. On the admission minimum data set (MDS), with an assessment reference date (ARD) of 12/12/2023, R136 was assessed as requiring partial/moderate assistance for bathing, upper body dressing, and standing from a sitting position, requiring substantial/maximal assistance of a helper for toileting and lower body dressing. Toilet transfers and walking were not attempted due to medical condition or safety concerns. The assessment coded R136 as frequently incontinent of bowel and bladder, having frequent severe pain, and utilizing scheduled and as needed pain medications. It documented the resident having a fall in the last month prior to admission with a major surgery during the 100 days prior to admission.The social services admission assessment dated [DATE] documented in part, .[R136] is adjusting to her new environment thus far. She arrived after 10:00 pm last night, 12/6/23, so her true adjustment is unknown at this time. There are no family supports in the area . Potential barriers/needs to meeting expressed goals (include physical barriers such as stairs, level of supervision/assistance available, location, lack of resources, etc.) Lives alone. 13 steps to bathroom level of home. No supervision. no family supports . Social Services staff will arrange home health, PT/OT/ST/Nurse/Aide (physical therapy/occupational therapy/speech therapy) and any equipment needed at discharge .The safe transition meeting for R136 dated 12/7/2023 documented attendance of the social worker, unit manager, rehab representative, business office manager, activities assistant and the resident. It further documented, .Patient's Transition Expectations: Return to home alone . Potential Barriers: Potential barriers to safe transition to desired destination (including financial/copay concerns, family/community support availability, etc.): Lives alone, 13 steps to bathroom on 2nd. level. No family in the area .A letter dated 2/5/2024 to the facility and R136 documented denial of appeals of the decision of Medicare Non-Coverage with services ending on 1/28/2024.The OT discharge summary for R136 dated 1/31/2024 documented in part, .Toilet transfer: Discharge (1/31/2024) Supervision or touching assistance . Discharge Recommendations: Home health services, Remove throw rugs, Remove environmental barriers, Assistive device for safe functional mobility. Elevated toilet seat/3 in 1 commode, shower bench (unpadded/over tub edge), Grab bars, Assistance w/ADLs (activities of daily living) and Lifeline for safety .The PT discharge summary for R136 dated 1/31/2024 documented in part, .Discharge Recommendations: Patient requires supervision for all bed mobility and transfer .The progress notes documented in part,- 1/19/2024 15:15 (3:15 PM) Social (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Services Note. Note Text: [R136] received her NOMNC (notice of Medicare non-coverage) with LCD (last covered day) 1/22/2024 and D/C (discharge) 1/23/2024. The appeal process was reviewed and the Livanta number given, [phone number] to be called by noon 01/21/2024. [R136] stated she is still not yet ready, unable to put any weight on her leg, and her other leg has become weak, so she plans to appeal once again.- 1/25/2024 18:55 (6:55 PM) Social Services Note. Note Text: [R136] was given and signed her NOMNC with LCD 1/28/2024 and DC 1/29/2024. Appeal information was provided. Appeal by noon 1/27/2024 by calling Livanta @ [phone number]. [R136] stated she would be appealing again, her wounds are not healing, and she is doing better in therapy.- 1/29/2024 09:53 (9:53 AM) Social Services Note. Note Text: [R136] lost her appeal Saturday, Jan. 27th. Liability begins today, 1/29/2024. She has filed a second level appeal.- 01/31/2024 14:58 (2:58 PM) Social Services note. LATE ENTRY Note Text: [R136] is being discharged [DATE]. Writer has attempted to order oxygen and a bedside commode, due to her bathroom being on the second floor of her home and her inability to walk or climb stairs. [R136] does not qualify for oxygen, as her O2 (oxygen) stats [sic] are above 90 with room air.- 2/1/2024 08:55 (8:55 AM) Nurse Practitioner Note . Pt to be discharged to home with home health and skilled nursing. Course at [Name of facility] included PT/OT, medication monitoring and pain management. In stable condition for discharge. RX (prescription) was provided to assigned nurse. Spent over 55 min on discharge planning, coordination, and education, coordinating DME with SW, assessing the pt, writing prescriptions and documentation . Recent discharge from a facility following Right knee replacement and wound management. The patient is unable to leave home because he/she is unable to negotiate stairs leading outside his/her home due to endurance, weakness or dyspnea .- 2/1/2024 12:35 (12:35 PM) Note Text : Resident discharged home, took all personal belongings including remaining medications.- 2/2/2024 11:32 (11:32 AM) Note Text : Home health was set up through [Name of home health agency], where she will receive PT/OT/Nursing and an Aide.The Notice of Transfer or Discharge for R136 documented an effective date of transfer home on 2/1/2024 due to The transfer or discharge is appropriate because your health has improved sufficiently that you no longer need the services provided by this center . The notice was dated as written on 1/25/24 with R136's name written on it. On 1/22/2026 at approximately 7:43 AM, administrative staff member (ASM) #1, the administrator, provided a printed copy of a chat between the facility and the DME provider for R136. The chat documented the social worker at the facility creating the order for the 3 in 1 bedside commode on 1/31/2024 at 5:11 PM with the order accepted by the DME provider on 1/31/2024 at 6:38 PM. The chat documented the order pending further review on 1/31/2024 at 6:59 PM and the DME company attempting to contact the resident on 2/1/2024 at 12:06 PM. A note from the DME company dated 2/1/2024 at 12:58 PM documented We contacted the patient/family. We are awaiting a callback to discuss financial obligation and delivery. We will continue our outreach if we do not hear back in a timely fashion. We just wanted to provide a quick update. Thank you! The next note was cancellation of the order on 3/27/2024 at 10:33 AM.ASM #1 also provided a fax from the home health agency which documented an email chain between staff at the home health agency. The first email dated 2/1/2024 at 10:50 AM sent the referral and eligibility form for review, the second email documented them leaving a message at 2:00 PM and to attempt to call again later. The third email documented staff calling again at 4:36 PM and the fourth email documented speaking with R136 at 4:59PM on 2/5/2024. It documented, I spoke to pt (patient) at 4:59pm. She fell at home when she was DC (discharged) on 2/1 and went to the emergency room. She refused to go back to [Name of facility] so she was admitted to [Name of other facility] I shared that we would be happy to provide her HH (home health) services upon her DC. This will be a canceled referral. Thanks .The information provided by ASM #1 failed to evidence the bedside commode delivery to R136's (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	home prior to them being discharged from the facility.On 1/22/2026 at 9:31 AM, an interview was conducted with other staff member (OSM) #10, the social services assistant who stated that she remembered R136. She stated that R136 had received a NOMNC and filed an appeal but had lost. OSM #10 stated that she had discussed with therapy about what DME R136 was going to need to go home with and had set up home health services. She stated that she had ordered a 3 in 1 commode for R136 that therapy had recommended for them. OSM #10 stated that she was not aware that the DME company had called R136 or that they had gone to the hospital. She stated that she had ordered everything prior to R136 going home and sometimes it was delivered to the home. She stated that R136 may have had a copay and that may have been the reason that it was not delivered. OSM #10 stated that they could only do what was required of them to do and that was why the 3 in 1 commode was ordered. She stated that they tried to make sure DME was delivered prior to discharge but they were at the mercy of the insurance. She stated that if the resident lived alone with no family and were dependent, they tried to let the home health agency know to expedite the service and that it should be documented in their notes if it were done for R136. OSM #10 stated that it was difficult for her because they were at the mercy of the insurance, but maybe she could have notified APS (adult protective services) that the resident was going home alone and dependent on someone for care. She stated that they could not go to each persons home to make sure they were safe and it was unfortunate because she did not know R136 had fallen. On 1/22/2026 at 2:43 PM, an interview was conducted with OSM #9, rehab director who stated that they did not remember R136. OSM #9 stated that the physical therapist and occupational therapist who worked with R136 during their stay no longer worked at the facility. She stated that she had reviewed the PT and OT discharge summaries for R136 and they were non-weight bearing to the right leg throughout their stay at the facility. She stated that at discharge, R136 was unable to bear weight on the right leg and was not able to go up or down stairs. OSM #9 stated that the discharge plan was for a bedside commode at home that was recommended by therapy, and it was set up by the social worker. She stated that R136 would have performed better if their weight bearing status had changed but the orthopedic physician had not allowed them to put weight on that leg. OSM #9 stated that R136 needed supervision at the time of discharge, but she could not determine by the notes whether it was constant or not. OSM #9 stated that therapy recommended the DME, but social services were the ones who set up and ensured that everything was in place at the time of discharge.On 1/22/2026 at 11:48 AM, an interview was conducted with licensed practical nurse (LPN) #9 who stated that she did not remember R136. She stated that when a resident was discharged home they provided patient teaching and educated the caregiver. She stated that therapy played a part in determining when a resident was ready for discharge and what DME was needed at home. LPN #9 stated that if a resident required assistance or if there were concerns regarding DME not being at home prior to discharge, she would speak with the social worker and physician to let them know that she did not feel that it was safe to discharge the resident. She stated that they could do peer to peer reviews but unfortunately the insurance usually made the decision. On 1/22/2026 at 3:30 PM, ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern.No further information was provided prior to exit.